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Supervision and Control in Euthanasia Law: Going Dutch?

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How can one encourage physicians to subject the practice of euthanasia to external supervision and control? This is the task that inevitably faces any government that comes to the conclusion that traditional means of protecting life via a strict criminal prohibition of euthanasia do not stop doctors from ending the life of their patient(s).

In this article we will examine how this task is dealt with in the Netherlands and Belgium: how the supervision and control systems for euthanasia are organised, how they function, and how after-the-fact and before-the-fact supervision and control are related to each other. The focus will mainly be on the situation in the Netherlands (on which the Belgian situation is modelled), with the Belgian situation presented as contrasting material.[1]

I. THE NETHERLANDS

a. The General Legal Context

Euthanasia in the strict—and, in the Dutch legal context, the only proper—sense refers to the situation in which a physician ends the life of a person who is suffering 'unbearably' and 'hopelessly' (ie, without prospect of improvement), at the latter's request. In the Netherlands, euthanasia seemed until 2002 to be explicitly prohibited by two nineteenth century provisions in the Dutch Criminal Code: section 293(1), which prohibits killing a person at that person's request, and section 294(2), which prohibits assisting in another

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1 For more information on the regulation of euthanasia in nine European jurisdictions, see J Griffiths, H Weyers and M Adams, *Euthanasia and Law in Europe* (Hart Publishing, 2008), on which this contribution builds. Many thanks to Isra Black, John Griffiths and Penney Lewis for commenting on a previous draft of this article. The usual disclaimer applies.

person's suicide.[2] Despite the clear and forbidding text of these provisions, in the early 1970s it began to become apparent that an absolute prohibition on euthanasia was not consistent with the demands of medical practice as understood by physicians.[3]

After some cases had been decided by lower courts and after the adoption of several policy positions by the Royal Dutch Medical Association (KNMG)[4]—a professionally and politically very influential actor—the Netherlands Supreme Court held in the 1984 *Schoonheim* case, in line with the policy positions just mentioned, that circumstances may justify a doctor administering lethal drugs to a patient at the latter's request.[5] More specifically, the key question was whether, according to responsible medical opinion, subject to the applicable norms of medical ethics the situation in which the physician found himself vis-à-vis the patient was one of 'necessity'.[6]

In the wake of this ruling the Dutch courts and the KNMG worked out the requirements of due care that doctors must meet when carrying out euthanasia. From 1987 it became clear that a doctor who complied with these requirements could assume that he would not be prosecuted. In this way, euthanasia achieved *de facto* legality in the Netherlands. The current euthanasia rules are thus the result of an intricate and subtle interplay between the medical profession and the Dutch courts. In 2002 legislation was enacted that codified the judicially created arrangements.[7] Provided certain conditions are met, the law of 2002 places physician-administered termination of life on request and assisted suicide beyond the purview of the criminal law. Besides reporting the case to the authorities as a non-natural death, these conditions ('requirements of due care') are as follows:

2 As far as their justifiability is concerned, Dutch and (at least in practice) Belgian law generally make no distinction between euthanasia and assisted suicide. In this article we therefore use the word 'euthanasia' to refer to both.

3 For more on the development of Dutch euthanasia regulation, see H Weyers, 'Euthanasia: The Process of Legal Change in the Netherlands. The Making of the Requirements of Careful Practice' in A Klijn, M Otlowski and M Trappenburg (eds), *Regulating Physician-Negotiated Death* (Elsevier, 2001) 11, and J Griffiths, 'Self-Regulation by the Dutch Medical Profession of Medical Behavior that Potentially Shortens Life' in H Krabbendam and HM ten Napel (eds), *Regulating Morality: A Comparison of the Role of the State in Mastering the Mores in the Netherlands and the United States* (Maklu, 2000) 173.

4 In 1984 the Association's Board took the position that euthanasia was a fact of medical practice and that the profession as a whole should come forward with an acceptable solution. According to the Board, euthanasia should be an option if the doctor involved complied with a number of requirements of due care.

5 Ruling of 27 November 1984, *Nederlandse Jurisprudentie* [Netherlands Case Law] 1985, no 106.

6 This defence may apply when someone is in a situation of conflicting duties and chooses to favour one duty over the other, even if this means doing something that in itself is forbidden. The conflict in this context is between a doctor's obligation to protect life on the one hand (as reflected in ss 293 and 294 of the Dutch Penal Code) and his obligation to relieve his patient's suffering on the other. Many countries recognise a defence similar to the necessity defence, but only in the Netherlands has it been used in the context of euthanasia. In the United Kingdom, Glanville Williams in 1957 pointed to something similar as being a 'solution' for euthanasia, although he did not believe it would be accepted by British judges. See Glanville L Williams, *The Sanctity of Life and the Criminal Law* (Alfred A Knopf, 1957) 322.

7 Termination of Life on Request and Assisted Suicide (Review Procedures) Act. Effective date 1 April 2002. For an English translation of this Act see www.nvve.nl/nvve-english/pagina.asp?pagkey=72087.

(a) the patient's request was voluntary and carefully considered;

(b) the patient's suffering was unbearable and there was no prospect of improvement;

(c) the doctor and the patient were convinced that there was no reasonable alternative in light of the patient's situation;

(d) the doctor consulted at least one other, independent physician who must have seen the patient and given a written opinion on the due care criteria;

(e) the doctor terminated the patient's life or provided assistance with suicide with due medical care and attention.

In the Netherlands the system of legal control over euthanasia and termination of life without a request is based on the fact that the attending physician is required to submit a certificate of cause of death. If he certifies that the patient died from a 'natural cause'[8] no further legal control takes place.[9] If a doctor is not sure that the death was a natural one (believing, for example, that it might have been the result of an accident or a criminal offence), he must notify the municipal pathologist to this effect. If the municipal pathologist is not convinced that the death was natural, he reports the case to the local prosecutor.

If the doctor considers the death 'not natural' because he himself has terminated the patient's life at the patient's request, there is a special model form (first promulgated in 1993) that he can use in reporting the case to the municipal pathologist.[10] If the doctor reports the case as one of euthanasia, the municipal pathologist sends the file to the appropriate regional review committee (see below).

8 What exactly amounts to a 'natural cause' is a matter of some confusion and disagreement. The operational definition in prosecution practice is said to be that a 'natural' death is 'one that comes from within', so that as far as doctors are concerned not only euthanasia but all deaths due to medical negligence must be considered 'non-natural'. See D van Tol, *Grensgeschillen: een rechtssociologisch onderzoek naar het classificeren van euthanasie en ander medisch handelen rond het levenseinde* [Boundary Disputes: A Legal-Sociological Study of the Classification of Euthanasia and Other Medical Behavior at the End of Life], Dissertation, University of Groningen, 2005, 61–70, on the tortured history of the idea of a 'natural' death.

9 For a doctor to file a certificate of 'natural' death in a case of euthanasia is a distinct criminal offence (under Art 228(1) of the Dutch Penal Code), in relation to which there have been a number of prosecutions. See G van de Wal and P van der Maas, *Euthanasie en andere medische beslissingen rond het levenseinde: de praktijk en de meldingsprocedure* [Euthanasia and other Medical Decisions in Connection with the End of Life: Medical Practice and the Reporting Procedure] (Sdu Uitgevers, 1996) 146–8 for some incidental prosecution data from which one can infer that prosecutions for falsely reporting a 'natural death' are rare, accidental events.

10 Use of this model form is, however, not required. In fact, over 95% of all doctors do use the form.

b. After-the-Fact Supervision and Control: The Regional Review Committees in the Netherlands

(i) Establishment and Relation to the Regular System of Criminal Prosecution

Regional review committees, which are tasked with assessing doctors' reports of euthanasia, were first established in 1998, with (among other things) the objective of making the process of review more acceptable to doctors, in the hope that they would be more inclined to report their behaviour. Between 1998 and the euthanasia law of 2002 the task of the committees was to advise the prosecutorial authorities as to whether the doctor concerned had complied with the requirements of due care concerning euthanasia. The committees reported their findings to the Committee of Procurators-General, which (subject to the approval of the Minister of Justice) made the final prosecutorial decision. It was policy only to deviate in exceptional circumstances from the conclusion of a committee that a doctor had complied with the legal requirements. In fact, no prosecution was brought contrary to a committee's advice, and in the four cases where a committee found the doctor's behaviour not to be in conformity with the legal requirements, the prosecutorial authorities nevertheless decided not to prosecute.

The Dutch euthanasia law of 2002, in addition to codifying the court-effected rules on euthanasia, placed the committees on a statutory footing. A committee's judgment that a reported case of euthanasia meets the statutory requirements now ends the matter and the prosecutorial authorities never see the case.[11] All cases in which a committee finds the doctor 'not careful' are sent both to the prosecutorial authorities and to the Medical Inspectorate.

In 2003 the Committee of Procurators-General (PGs) issued guidelines on prosecutorial decision-making in light of the new law of 2002 (revisited in 2007).[12] Most of the guidelines are devoted to a detailed description of the decision-making procedure in reported and non-reported cases. The requirement of suffering is of 'such essential importance' that prosecution is in principle indicated if the review committee finds the doctor 'not careful' because the suffering was not unbearable and without prospect of improvement, or if it is not able to determine this because of the doctor's failure to consult another doctor or to maintain adequate records. If the review committee finds the doctor 'not careful' because the patient's request was not voluntary and well considered, prosecution is also in principle indicated. If the review committee finds the doctor 'not careful' because of a failure to consult another independent doctor, but the euthanasia was otherwise properly carried out, prosecution will be unwarranted: a talk with the doctor in which his attention is called to the requirements will suffice. If the review com-

11 Unless the prosecutorial authorities or other legal control agencies happen to hear about the case from another source than the doctor's notification, and have reason to follow up on it.

12 See *Staatscourant* [State Gazette] 2007, no 46, p 14 (6 March 2007).

mittee finds the doctor 'not careful' in the way he carried out the euthanasia, this does not call, in general, for criminal prosecution, and the Medical Inspectorate should deal with the matter. In effect the PGs distinguish between the substantive requirements for euthanasia (suffering and request) and the procedural requirements, observing that the justification of necessity is in principle still available in cases where only the latter are at issue.

(ii) Procedures

The law of 2002 and an Order in Council pursuant to the law provide for five regional review committees with competence to deal with reported deaths due to euthanasia. Each committee consists of three members: a lawyer (who acts as chairman), a doctor and an ethicist; there are three substitute members, of the same three disciplines. All are appointed by the Ministers of Justice and of Health for a period of six years, with the possibility of one renewal. Each committee also has a secretary and one or more substitute secretaries; all are lawyers appointed by the two Ministers and are exclusively responsible to the committee for whom they work. They are responsible, among other things, for preparing draft decisions in cases to be handled by their committee.

The Ministers appoint one of the chairmen as coordinating chairman, responsible for initiating and coordinating meetings of the regional chairmen with representatives of the prosecutorial authorities and of the Medical Inspectorate. The Ministers also appoint a general secretary, who is responsible for coordinating the work of the secretaries, coordinating the preparation of the annual reports, initiating consultation among the secretaries and, on request, providing the Ministers with information.

The members and secretaries of the committees are specifically forbidden to express a judgment *in advance* concerning a doctor's inclination to perform euthanasia.[13] They are bound to secrecy concerning information about individual cases that they come to know while carrying out their responsibilities; copies of the dossier made for purposes of a committee's decision-making are to be destroyed after a case is disposed of. The law of 2002 requires the committees, on request, to provide the prosecutorial authorities with all information they require for assessing a case in which the committees have found the doctor 'not careful', or in connection with a criminal investigation.

The committees are responsible for the registration of basic data concerning the cases reported to them and for producing an annual report of their work, due before 1 April of each year. The report must at a minimum include the number of cases handled, the nature of these cases, and the committees' judgments and the reasons leading to them. In 2006 the regional review committees began publishing cases and judgments, in which all identifying information had been removed, on their website.

13 See part c for information on before-the-fact control.

(iii) Judgments and Follow-Up

Following the enactment of the euthanasia law in 2002, at first the number of reported cases dropped: there were 2,045 cases reported in 2001, 1,882 reported in 2002 and 1,815 reported in 2003. Thereafter reporting started to increase: 2004: 1,886; 2005: 1,933; 2007: 2,120; 2008: 2,331; 2009: 2,636 and 2010: 3,136.[14]

The rise in the number of reported euthanasia cases increased the workload of the committees severely, with no corresponding increase in personnel or resources. Since 2009, this has resulted in failures to issue judgments within the required time span of 12 weeks. The committees' plans to publish reported cases and judgments on the Internet have also not yet come to fruition.

Most cases that reach the committees are unproblematic. And in most cases that are discussed in detail the committees ultimately come to the conclusion that the doctor was 'careful'. Only a handful of cases are adjudged 'not careful' and referred to the prosecutorial authorities for further consideration. Since 2002 there have been 52 such cases.[15]

To date there have been no prosecutions in the cases found to be 'not careful' by the regional review committees. In the most recent annual reports (2009 and 2010), the committees report on the progression of those cases. It turns out that (just as before the enactment of the law) doctors who do not comply with the requirement of consultation or the requirement that euthanasia is carried out in a professionally responsible way will not be prosecuted (in conformity with the guidelines for prosecutorial decision-making). Instead, the doctors involved are generally invited to an interview with the Medical Inspectorate.

Between 1998 and 2010, the committees produced published judgments (in their annual reports) for some 158 cases. A general appraisal of these judgments can be short: they are a goldmine of information. They inform the audience about the development of the law, about the problems doctors encounter with the system of control, and how they are dealt with by the committees. Less directly they concern how the system of control is functioning; and still less directly they concern euthanasia practice itself. The quality of the judgments as case law is roughly comparable in these three different respects to that of Dutch courts and other adjudicatory tribunals.

Consultation, due medical care and attention, and euthanasia and different types of patients have been themes of debate in the committees. From the annual reports we can learn how they interpret the law in these respects:

a. Consultation: the law of 2002 requires that the doctor consult at least one other, independent doctor, who sees the patient and files a written report. From the reports of the committees it appears that implementation of the requirement gives rise to problems

14 RCC Jaarverslag [Annual Report] 2002–10.

15 In 2002: 5; 2003: 8; 2004: 4; 2005: 3; 2006: 1; 2007: 3; 2008: 10; 2009: 9 and 2010: 9.

concerning the independence of the consultant, the timing and quality of consultation, and whether the consultant must agree with the consulting doctor's judgment. The review committees, which have been confronted with a considerable number of cases in which the consultant's independence is at issue, define independence in a rather flexible way—requiring the consultant to be able to make an 'independent judgment'.[16]

With respect to timing:[17] consultation should be neither too late nor too early. On the one hand, consultation should not be postponed until it is no longer feasible, either because the patient's physical condition is declining so quickly that waiting for consultation is not possible or because the patient is no longer capable of communicating with the consultant. On the other hand, consultation far in advance has a hypothetical character which makes it unsatisfactory as a double check that the requirements of due care have been met when the euthanasia is carried out. The solution to this problem has been found in a process of two-step consultation. If the first consultation takes place early on, when there is not yet any question of unbearable suffering and the patient's request has a hypothetical character, then the consultant must visit the patient a second time. If the consultant expects that the suffering will soon become unbearable and shortly thereafter this is indeed the case, then, depending on the circumstances, no further contact with the consultant may be necessary, or telephone contact between the doctor and the consultant may suffice.[18]

A recurrent point of discussion regarding consultation concerns the situation in which the consultant disagrees with the judgment of the consulting doctor that the requirements of due care have been met: is the consulting doctor bound by the disagreement, or is he free to exercise his own judgment? The regional review committees have settled this matter. They expect a doctor who proceeds despite the contrary judgment of the consultant (even if he later consulted a second doctor who did agree with him) to explain his decision. But '[i]n a case of a difference of opinion between the doctor and the consultant it is ultimately up to the doctor to make a decision'.[19]

b. 'Due medical care and attention': the law does not define 'due medical care and attention'. In their interpretation the review committees took as their point of departure the notion that with respect to choice of drugs, doctors should comply with the relevant

16 RRC 2005.

17 Often when a regional review committee finds that consultation has not met the requirements, failure to arrange for timely consultation is the underlying problem, and not no consultation at all.

18 RRC 2005.

19 RRC 2005. That doctors usually appreciate the consultations is shown in a study by Van Wesemael: Of the 433 SCEN consultations that took place in 2002, euthanasia was performed in 59.4% of cases, with euthanasia being performed in only 2.3% of cases where the SCEN consultant had given a negative opinion in respect of the request (Y van Wesemael, 'Consulting a Trained Physician when Considering a Request for Euthanasia: An Evaluation of the Process in Flanders and the Netherlands' (2010) 33 *Evaluation & the Health Professions* 497).

medical guideline.[20] A doctor is allowed to deviate from the guideline but, if he does so, he will be questioned on his reasons. When these reasons are considered insufficient, a 'not careful' judgment will follow. The cases highlighted by the committees concern choice of drug and, in particular, the amount of sedative needed to induce a coma prior to the administration of the lethal drug.[21] A doctor who deviates from the required amount, but controls the depth of the coma adequately, will be judged as having acted 'carefully'.[22]

c. Euthanasia and psychiatric patients: the law does not differentiate between patients with psychiatric illness and patients with 'merely' somatic diseases. From case law prior to the enactment of the law of 2002,[23] it is clear that assistance with suicide can be lawful in both situations. In cases of psychiatric illness, however, an especially high degree of care is required. According to the guideline of the Association of Psychiatrists,[24] there should be formal consultation with one—and in difficult cases more than one—independent psychiatrist. The review committees have judged a few of these cases and considered them 'careful'.[25]

d. Euthanasia and comatose patients: a cancer patient at the end of life can lose consciousness. Because it is generally accepted that a patient in a (deep) coma does not suffer unbearably (anymore), this poses a problem in cases where the doctor and the patient had agreed on euthanasia. The review committees have taken the position that doctors should be very reluctant to perform euthanasia if a patient is no longer able to speak. In the course of their discussions, the committees asked the KNMG to adopt a position on this issue.

The resultant guideline[26] adopts the Glasgow-coma score as a point of reference for deciding whether the patient is in a deep coma (and is no longer suffering) or in a more superficial unconscious state. Therefore, the depth of the coma is decisive for the permissibility of the euthanasia. A score of 6 or below indicates no consciousness at all

20 KNMP [Koninklijke Nederlandse Maatschappij ter bevordering der Pharmacie/Royal Dutch Association of Pharmacies], *Toepassing en bereiding van euthanatica* [Application and Preparation of Euthanasia] (The Hague, 2007).

21 RRC 2008.

22 RRC 2009.

23 The Chabot case (ruling of 21 June 1994), *Nederlandse Jurisprudentie* [Netherlands Case Law] 1994, no 656.

24 NVP [Nederlandse Vereniging voor Psychiatrie/Dutch Association for Psychiatry], *Het verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis: richtlijn hulp bij zelfdoding* [The Request for Assistance with Suicide in the Case of Patients with a Psychiatric Disorder: Guideline for the Psychiatrist] 2004.

25 RRC 2008, 2010.

26 KNMG, *Euthanasie bij een verlaagd bewustzijn* [Euthanasia and Lowered Consciousness] (Utrecht, 2010).

and therefore no suffering. Carrying out euthanasia in such cases should be considered 'not careful'.

Besides the depth of the loss of consciousness the KNMG guideline draws a distinction with respect to its cause. Usually a coma develops as a result of the illness of the patient. Sometimes, however, it is induced by medical acts. In principle this coma is reversible: it is (at least theoretically) possible to lower the quantity of drugs until it becomes possible to discuss the euthanasia with the patient. But if this were to be done, the patient would suffer severely again. The guideline stipulates that in such a situation it is acceptable to carry out euthanasia notwithstanding the apparent lack of suffering.

e. Euthanasia and patients with dementia: one of the issues in the parliamentary debates on the euthanasia law concerned the legality of euthanasia for patients suffering from dementia. By now it is clear that doctors occasionally (very seldom in relation to the total number of demented patients) carry out euthanasia on these patients. The review committees observed in a few reported cases that some patients suffer from a special and painful combination of early stages of dementia and insight into their future (often from previous experiences with family members). This combination enables them competently to assess themselves and their future and make clear that their suffering is unbearable. The committees decided that these reported cases were 'careful'.[27]

f. Euthanasia and being 'tired of life': another question in the parliamentary debates was whether patients who suffer unbearably from being 'tired of life' should be able to have their life ended legally under the law of 2002. The Minister of Justice and many members of Parliament took the position that this should not be possible. At the same time, the Dutch Supreme Court judged that euthanasia in these situations was beyond the professional competence of a doctor. From the annual reports (2009 and 2010), it is clear that the review committees take a slightly different view. In their opinion, the question to be answered is whether the doctor could reasonably be satisfied that the suffering of the patient was unbearable and hopeless. If so, the assistance with suicide has been judged 'careful'. The committees note that in the reported cases 'the cause of the hopeless and unbearable suffering always could be traced back predominantly to a medically classified disease'.[28]

(iii) Reporting Rates

An important question is whether the reported cases mirror euthanasia practice. We think we can answer this question positively. Thus far, four official studies into the nationwide practice of euthanasia have been carried out (the fifth study is currently

27 RCC 2000, 2004–2010.
28 RCC 2010.

underway). In these the numbers of deaths due to euthanasia are estimated at about 2,700 in 1990; 3,600 in 1995; 3,800 in 2001; and 2,400 in 2005.[29] Besides the number of euthanasia cases, the reporting rates were also estimated: 1990: 18%; 1995: 41%; 2001: 54%; and 2005: 80%.

The estimated reporting rates have given rise to much discussion since the first study. A strong impetus came from an article by Den Hartogh,[30] who doubted the reporting rate of 2001. Den Hartogh argued that there might be a difference between the way doctors classify 'euthanasia' and the way the researchers who carried out the nationwide study did so. His presumption was that doctors would not classify as 'euthanasia' cases of terminal sedation and cases of possible life shortening with morphine. And if they would not classify this behaviour as 'euthanasia', they would not report it (and, in our opinion, they are legally speaking right in doing so). Den Hartogh's recalculation resulted in a reporting rate of 90% in 2001. The psychologist Van Tol has shown convincingly that there are major systematic differences in the way the various participants (doctors, prosecutors, national researchers) classify deaths as 'euthanasia' or as something else. Doctors classify as 'euthanasia' prototypical cases in which a doctor administers by injection an immediately lethal substance (not morphine) to a patient on his request at a moment agreed beforehand. Van Tol's interviews with doctors suggest that they report almost all cases they themselves classify as 'euthanasia'.[31]

The researchers apparently agree with the conclusion that they miscalculated the reporting rates (ie that there is a discrepancy between their classifications and those of doctors). In the 2005 study, a new question was added in which the doctor himself was asked to classify what he did. In about a quarter of all cases in which the researchers classified the doctor's behaviour as termination of life (euthanasia, assisted suicide, or termination of life without a request), the doctor classified it differently—usually as palliative or terminal sedation or as pain relief. In 99% of all cases in which muscle relaxants were used, the doctor's classification was 'termination of life'. The recalculated rate after exclusion of cases involving opioids was 99%. We therefore conclude that the cases reported to the review committees mirror almost perfectly the quantitative aspect of euthanasia practice.

29 The decline in the number of euthanasia cases in 2005 does not match the rise from the earlier studies. The new study will show whether this is an anomalous result.

30 G den Hartogh, 'Mysterieuze cijfers: meldingspercentage van euthanasie kan niet meer stijgen' [Mysterious Numbers: Further Increase in the Reporting Rate is Not Possible]' (2003) 58 *Medisch Contact* 1063.

31 Van Tol (n 8) 2005. Van Tol also shows that public prosecutors do not classify cases in the same way as the researchers who conducted the national studies. It follows that there are three possible reporting rates for 2001, depending on whose classification is used: a little over 30% according to the classification of prosecutors, a little over 50% according to the classification used by the researchers, and over 90% according to the classification of doctors. Van Tol concludes that 'the level of the reporting rate is highly dependent on the perspective from which situations ... are classified' (292).

c. Before-the-Fact Supervision and Control (SCEN)

The availability of independent, qualified doctors to function as consultants *prior to* carrying out a patient's request for euthanasia, and the quality of consultation, have been matters of concern ever since the institutionalised system of legal control was established. A number of proposals were made over the years to formalise the consultation procedure, for example by appointing specially qualified doctors to perform the function. In 1997, the KNMG, with financial support from the Ministry of Health, set up an experimental program in Amsterdam to provide a corps of trained advisors and consultants to be available to family doctors in Amsterdam. This so-called SCEA[32] program trained a corps of doctors in all aspects of euthanasia consulting (medical, ethical and legal). SCEA consultants were available to family doctors, both for advice on the requirements for euthanasia and for formal consultation. The project was generally regarded as very successful, and in 1999 it was made permanent and extended to the entire country (it is now known as SCEN). In 2002 the regional review committees informed the Ministry of Health that continuation of the programme and expansion to cover medical specialists was in their view very important 'because it makes an important contribution to the quality of due care in connection with euthanasia'. In the view of the committees, thanks to SCEN the quality of consultation and of the reports of consultants has improved greatly in cases in which euthanasia is carried out by a family doctor, and they describe the quality of SCEN consultants' reports as 'generally excellent'.

In recent years SCEN has expanded to include hospitals and nursing homes. There are now some 590 SCEN consultants (most are general practitioners, almost 60 of them are nursing home doctors, and around 80 are specialists in hospitals). Throughout the country it is possible to ask for a SCEN consultant.[33]

To become a SCEN doctor a doctor must have five years' experience as a practitioner. He should have an affinity with euthanasia and experience with medical behaviour that potentially shortens life. Furthermore, he should be willing to serve in the region and to participate in three regional meetings a year. Before he can work as a SCEN doctor he must successfully complete a three-day course. The aims of the training program are to be able to advise a doctor, to write a report on the consultation that fulfils the requirements, to talk with a patient, and to identify possible alternative ways to relieve the patient's suffering.[34]

32 SCEA stands for Steun en Consultatie Euthanasie Amsterdam [Support and Consultation on Euthanasia in Amsterdam].

33 http://knmg.artsennet.nl/Diensten/SCEN.htm. SCEN consultants receive a maximum of €340 for a consultation.

34 In 2012 the KNMG published a guideline on good support and consultation in cases of euthanasia: KNMG, *Goede steun en consultatie bij euthanasie* [Euthanasia: Good Support and Consultation] (Utrecht, 2012).

In 2008 SCEN was evaluated. In sum, the SCEN doctors were formally consulted 3,200 times that year.[35] The mean for each SCEN-doctor is seven times a year (although there are major regional differences). In almost 20% of cases, the SCEN-doctor concluded that the requirements of due care were not met. The vast majority of SCEN consultations are undertaken at the request of family doctors: 83% in 2008. 6% of the consultations took place in a home for elderly people, 5% in a hospice, 4% in a hospital and 3% in a nursing home. The study also showed that doctors appreciate the independent view of SCEN doctors and that they can give advice when a doctor is uncertain about carrying out euthanasia. In those cases doctors value the experience and knowledge of the SCEN doctors.[36]

From another national study, it appears that a SCEN consultant was involved in almost 90% of all cases of euthanasia. The remaining 10% of cases were about equally divided between cases of no consultations and cases of consultation with a non-SCEN consultant.[37]

d. An Assessment of the Dutch System of Supervision and Control

One of the most important advantages of the review committees is the transparency of what they do. Prior to 1998, when decision-making on reported cases was entirely in the hands of the prosecutorial authorities, practically nothing was known publicly about what they did, or how, or why. The annual reports of the review committees are a mine of both quantitative and qualitative information.

The transparency produced by the committees is, however, not only a consequence of their annual reports. Each committee consists of three members and three alternates. These people mostly do their committee work on the side, being primarily active professionals in universities, hospitals, the judiciary, etc. Several of them are also prominent scholars and authors in related fields. Through their contacts with colleagues who are interested in the workings of the committees, and through more formal presentations, a great deal of information concerning the functioning of the committees becomes known to scholars, policy-makers and others concerned with the way control over euthanasia is working in practice.

SCEN seems to be developing in the direction of before-the-fact control of euthanasia: reviewing the doctor's proposed course of conduct before he carries it out. There is an obvious advantage to before-the-fact control, since after-the-fact control always

35 And 1,000 times asked for advice.

36 B Onwuteaka-Philipsen *et al*, *Evaluatie van SCEN: wat is goede steun en consultatie? Mogelijkheden voor verdere professionalisering* [Evaluation of SCEN: What Counts for Good Support and Consultation? Possibilities for Professionalisation] (ZonMw, 2010).

37 B Onwuteaka- Philipsen *et al*, *Evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [Evaluation of the Termination of Life in Request and Assisted Suicide (Review Procedure) Act of 2002] (ZonMw, 2007).

comes too late for the individual who receives euthanasia in inappropriate circumstances. From the beginning of the Dutch euthanasia debate, the idea of before-the-fact control (special committees, a special division of the courts, etc) has been more or less continuously present as a subterranean theme which, whenever it comes to the surface, has been regularly rejected by doctors and by the government. A variety of reasons have been given for exclusive reliance on after-the-fact control: the traditional resistance of the medical profession to any sort of shared decision-making or dilution of the ultimate responsibility of the individual doctor, practical problems of organising a system of before-the-fact control, the impossibility of anyone giving approval to behaviour that was for a long time 'illegal', the undesirability of bureaucratising the process, ethical objections to involving the state in decisions to administer euthanasia, and so forth.

In spite of the resistance to before-the-fact control, the annual reports of the regional review committees give the impression that the committees are increasingly inclined to regard a report of euthanasia that is accompanied by the report of a SCEN consultant as requiring less attention than other cases. If this is true and becomes known among doctors, one can expect them to be increasingly prepared to make use of SCEN consultants since this will more or less guarantee that they will not experience unpleasantness later on. In short, the logical momentum of the way in which the committees interact with the SCEN program seems to be leading to a situation where the latter are gradually taking over much of the role of the former. And when that is accomplished, we will have a *de facto* system of before-the-fact control, with the review committees principally acting as a backup to SCEN in particularly difficult cases.

II. BELGIUM

a. The General Legal Context

At the outset, it is necessary to mention that, as compared with the Netherlands, one cannot (yet) appeal to a qualitatively and quantitatively significant amount of Belgian case law, legal doctrine and academic research on the practice of euthanasia. Although all this is improving, a great deal of caution must nevertheless still be exercised when interpreting Belgian euthanasia practice and the Euthanasia Act,[38] especially with regard to the topic that is central to this article. Furthermore, empirical information on the practice of euthanasia provided by the so-called Federal Control and Evaluation Commission does not, as we will explain below, include information on its own functioning.

In Belgium, euthanasia was apparently illegal until 2002, when, after a relatively short legislative process that only formally began in the summer of 1999, legislation

38 For an English translation of the Belgian Euthanasia Act, see www.kuleuven.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23. Effective date 29 September 2002.

was passed legalising it along lines similar to those in the Netherlands. Before that time, euthanasia undoubtedly took place in actual medical practice, but, contrary to the situation in the Netherlands, there had never been a prosecution or court decision in which the possibility of a legal justification could be tested. The public prosecutor's office had never even initiated proceedings against anyone. It is precisely the lack of case law on this topic in Belgium that is one of the reasons why the Belgian Act, as compared with the Dutch law, contains so many detailed provisions. Having said that, however, it seems to be a reasonable conclusion that the material differences between Belgian and Dutch law, on the whole, are fairly minor.[39]

b. After-the-Fact Supervision and Control: The Belgian Federal Control and Evaluation Committee (FCEC)

As in the Dutch case, a special procedure has been designed to review reported cases of euthanasia. The Federal Control and Evaluation Commission (FCEC) established by the Euthanasia Act assumes the role that in the past would have been performed by the public prosecutor if a doctor had reported performing euthanasia.

The FCEC is composed of 16 members (eight doctors, four lawyers and four members 'from groups charged with the problem of incurably ill patients'). As a result, what would previously have been an exclusively criminal assessment has now developed into a professionally and socially oriented assessment with the criminal law present only in the background. The aim of this is to encourage doctors—who are understandably wary of the criminal justice system—to report cases in which they have performed euthanasia. As in the Netherlands, this was expected to yield more effective social control of euthanasia as well as better insight into (and, it is hoped, improvements in) the actual practice of euthanasia.

The Euthanasia Act provides that a doctor who has performed euthanasia must complete a registration form and submit it within four working days to the FCEC. The form consists of two parts, both of them confidential. The first part includes information on the identity of the patient and physicians concerned, as well as other persons (eg confidants). The second part of the doctor's report includes information which makes it possible to judge whether or not the conditions of the Euthanasia Act were met (time and place of death, the nature of the serious and incurable condition, the persistent and unbearable suffering and the reasons why this suffering could not be alleviated, the elements underlying the assurance that the request was voluntary, well considered and

39 The most important material differences seem to be the special treatment of advance requests for euthanasia and of non-terminal patients in the Belgian Act, and the position of minors (for which Dutch law makes provision, and Belgian law does not). Although the law is not entirely clear, it also seems that the patient is under Belgian law in the position of being more autonomously able to state when he or she is suffering unbearably. See M Adams and H Nys, 'Comparative Reflections on the Belgian Euthanasia Act 2002' (2003) 11 *Medical Law Review* 353.

repeated, and not the result of external pressure, etc). The Commission studies the second part of the registration form and determines whether the euthanasia was performed in accordance with the conditions and the procedure stipulated in the Euthanasia Act. In case of doubt, the Commission may decide by simple majority to lift anonymity and examine the first part of the registration form. The Commission may also request that the responsible doctor provide any information from the medical record having to do with the euthanasia.

The Commission is required to submit biennial reports. Four of these reports have been issued to date, the last one in 2010.[40] They include a statistical summary of the information from the second part of the completed registration forms submitted by doctors; a description and evaluation of the implementation of the Euthanasia Act; and, if appropriate, recommendations that could lead to new legislation or other measures concerning the implementation of the Euthanasia Act.

The Commission renders judgment within two months. If, in a decision taken by a two-thirds majority, the Commission is of the opinion that the conditions laid down in the Euthanasia Act have not been fulfilled, it turns the case over to the public prosecutor of the jurisdiction in which the patient died. According to the 2010 report, 85% of submissions were approved by the committee without further ado. In the remaining 15%, part I of the registration form was studied in order to point out to the physician small mistakes of interpretation concerning the procedure or incomplete answers (4%), or in order to ask the physician for further information (11%). In the first eight years of the operation of the Law (until 2010), no adverse judgment has been rendered.

What is also clear from the latest biennial report is that the number of reported cases of euthanasia is on average 63 per month. Reporting is increasing over time; the actual percentage of physicians that actually report euthanasia is not known, although 0.7% of all deaths are reported to the FCEC. The vast majority of reported cases come from the Dutch-speaking region of the country (Flanders): 80% vs 20% of the total amount! This figure is striking, and a number of considerations may be relevant to explain it.[41] One is that the practice of euthanasia is indeed more frequent in Flanders than in Wallonia (although this cannot fully explain the difference). Another is that euthanasia is reported far less frequently in Wallonia because of socio-cultural differences between the two main Belgian regions (which reveal a different attitude towards reporting). A further explanation might be that in recent decades the population of Flanders may have been more exposed to and influenced by Dutch practice just across the border (where the same language is spoken), and may therefore have 'caught up with' Dutch attitudes towards reporting (which are very positive amongst Dutch physicians) more quickly.

40 They can be found at www.leif.be/nl/professioneel/professionelegids.html.

41 Y Van Wesemael, *The Euthanasia Practice in Belgium: Evaluation of the Mandatory Consultation Procedure between Physicians*, Dissertation, Free University Brussels (2011), 53–68.

c. Before-the-Fact Supervision and Control: Specially Trained Consultants (LEIF)

One additional explanation for the difference highlighted above was provided by the FCEC in 2004. The FCEC suggested that the establishment of a corps of specially trained consultants in the Dutch-speaking part of Belgium shortly after the introduction of the Euthanasia Act in 2002 may account for a higher level of relevant knowledge among Flemish doctors: LEIF (Forum for End of Life Information) is a program similar to SCEN in the Netherlands. By contrast with the Netherlands, not only GPs but also specialists were included in the project from the beginning (the Netherlands is, however, catching up on this). An equivalent organisation (Médecins EOL) was set up in Wallonia (ie, the French-speaking part of Belgium), but there exists very little reliable information regarding this organisation.

LEIF and SCEN were established in entirely different settings.[42] Whereas SCEN was an initiative of the Royal Dutch Medical Association and the Dutch Association of General Practitioners, in order to professionalise existing and officially recognised euthanasia practice, LEIF was an initiative of individual professionals with experience in palliative care, and of the association 'Right to Die with Dignity'. The aim was to create a service that could refer physicians to health care professionals specialised in end-of-life matters, and also to increase physicians' knowledge regarding palliative care and euthanasia through training programs. The scope of LEIF is thus broader than that of SCEN, including, as it does, consultation in other end-of-life decisions (including palliative care). Both organisations offer training modules of roughly 23 hours given by experts, spread over several weeks. There are currently some 590 SCEN physicians, corresponding to one per almost 28,000 inhabitants or one per 112 physicians in the Netherlands. In Belgium there are 161 LEIF-physicians, ie one per 44,800 inhabitants or one per 177 physicians in Flanders. An important difference between the organisations is that SCEN receives substantial financial support from the national government, which is not the case in Belgium. Possibly as a result of this, SCEN is more highly regulated since its organising body, the Royal Dutch Medical Association, is itself also financially supported by the government. LEIF has no controlling body and little funding.

What is important to note here is that Dutch euthanasia evaluation research has demonstrated consultation services to be of great importance to the careful performance of euthanasia in the Netherlands. Moreover, there is a relationship between a consultation with SCEN and reporting of euthanasia.[43] The Dutch evaluation report of the euthanasia law also showed that SCEN physicians had been involved in 89% of all reported euthanasia cases in the Netherlands.[44] In Belgium, the notification reports and

42 The remainder of this paragraph relies on the research by Van Wesemael, *ibid*, 71–85.

43 Although the number of consultations with non-SCEN physicians is very small, which prevents strong statements on this issue.

44 Onwuteaka-Philipsen et al (n 37).

a first assessment of LEIF activities indicated that LEIF physicians had acted as consulting physicians in 54% of reported euthanasia cases in Flanders.[45]

d. An Assessment of the Belgian System of Supervision and Control

On the one hand, the statistical reporting by the Belgian FCEC is exemplary and affords a much greater insight into the quantitative characteristics of reported cases than do the annual reports of the Dutch regional review committees. On the other hand, the FCEC's biennial reports give very little information concerning its own functioning as a control institution. Unlike the Dutch review committees, the FCEC is in that respect (still!) largely a black box. Its reports provide no information that contributes to legal development,[46] do not provide feedback to the medical profession as a whole, and hardly afford a basis for informed public and political control over how the Commission reaches its judgments or why. Nor can one distil from the biennial reports much insight into the range of informal sanctions available to the Commission. We know that some doctors are asked for additional information, but whether in this context suggestions are made regarding improvement of practice is unknown. Nor do we know whether the FCEC has taken any active steps to influence euthanasia practice in institutions. And finally—and unfortunately—the FCEC, which could use its unique position to form an opinion on the matter, has so far not given any specific indication concerning the contribution of specialised LEIF consultants to careful euthanasia practice. As we saw, research suggests that in 2008 these consultants were involved in more than half of the euthanasia cases in Flanders. But how this relates to the actual practice of the FCEC remains, for the reasons provided in this paragraph, unclear. In short, a Commission whose *raison d'être* is to produce transparency and thereby maintain confidence in euthanasia practice, itself suffers from a regrettable absence of transparency.

Having said this, however, it is also worth noting that in the Netherlands the process of supervision and control is approaching its 30th year. It has thus had time to establish itself and bed down. There are signs that developments in Belgium are not actually so different compared to the Netherlands. For example, judging from the successive biennial reports there has been a more than fourfold increase in the annual number of reported cases over a period of 8 years. The acceleration was rapid in the first period: 8 per month in the first quarter, 14 per month in the second, 21 per month in the next three, 29 per month in 2004, and 33 per month in 2005. According to the last report the figure now stands, as we saw, at 63 per month on average. The pattern is reminiscent of the early 1990s in the Netherlands, when the reporting procedure was becoming institu-

45 Y Van Wesemael *et al*, 'Role and Involvement of Life End Information Forum Physicians in Euthanasia and Other End-of-Life Care Decisions in Flanders, Belgium' (2009) 44 *Health Services Research* 2180.

46 Although in very general terms the FCEC has made it clear through its successive biennial reports that it accepts euthanasia with incompetent patients (with a living will), some neuro-psychiatric patients (dementia, depression), and patients who are tired of life.

tionalised and had to settle. Nevertheless, transparency is required in order to establish in the medical profession a sense of responsibility for appropriate medical behaviour in this context and for reporting. It is time for the FCEC to work on this, especially since in practice the FCEC is inevitably the interpretative locus of the Belgian Euthanasia Act.

III. SOME FINAL REMARKS AND OBSERVATIONS

In this article we have attempted to provide information regarding the features and functioning of the intricate supervision and control systems that have been installed in the Netherlands and Belgium in the context of euthanasia regulation. All of this brings us to some final remarks and observations.

On first impression, the Dutch and Belgian control systems do not appear to involve much 'sanction pressure' on doctors; physicians performing euthanasia are hardly ever prosecuted. However, before jumping to the conclusion that these systems are all bark and no bite, one should consider that the legal obligation to report is itself a form of prospective control: knowing that one will have to report colours the behaviour that will be reported. The reporting system might thus induce doctors either not to perform euthanasia where the rules do not allow it, or to perform it in the right way. Furthermore, the growing use of trained consultants is not only a form of supervision and control in advance, but also functions as an institutionalised means of transmitting relevant information to doctors, adding to a variety of other institutional (eg hospital protocols) and non-institutional (eg professional journals) means by which they are kept informed. Within the control system itself, doctors are sometimes required to provide more information and explain their behaviour in person to the committees, in the Netherlands as well as in Belgium. In practice, many doctors apparently experience this as a significant sanction. That the cases judged 'not careful' in the Netherlands have not been prosecuted does not mean that nothing at all is done. There have been discussions with prosecutors and medical inspectors and some cases are only conditionally dismissed.

The main characteristic of the Dutch euthanasia control system is a primary focus not on repressive control but on increasing the transparency of medical practice. This comes together with transmitting information concerning careful practice to doctors, keeping doctors aware that by contrast with 'normal medical practice' this sort of medical behaviour is subject to specific scrutiny, and letting a doctor know in dubious cases that his behaviour was not acceptable. It seems at least highly likely that such a system will be more successful in achieving a high level of conformity with the applicable legal norms—which, after all, on the whole emerged from and enjoyed the support of the medical profession itself—than would a system that concentrated on meting out punishment in those few cases of transgression that happened to come to its attention. What we in any case have seen is that there is, at least in the Netherlands, a distinct evolution

taking place from supervision and control *after the fact* to supervision and control *in advance*. In effect, consultation with a specially trained SCEN consultant is gradually becoming the context in which a doctor's (proposed) behaviour most frequently takes place and is scrutinised. The development of LEIF in Belgium may also herald a similar shift in the locus of supervision and control, but due to a lack of information it is not yet possible to draw firm conclusions on this.

Taking an overview of the supervision and control system, it seems moreover fair to say that the Dutch and Belgians have not freed doctors from the constraints that bind their colleagues in other countries. On the contrary, they have subjected the behaviour of doctors to much more legal scrutiny (broadly defined) than used to be the case, and to much more public attention than it attracts elsewhere.